

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036039

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4978

FILED SEP 25 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Kansas City	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Memorah Hospital		d. STREET ADDRESS (If outside, give location) 5707 E 24th St	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WALTER Middle LEWIS Last CHAPMAN Sr.			4. DATE OF DEATH Month Sept Day 10 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/4/1907	9. AGE (last birthday) 55	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Ford Motor Co	11. BIRTHPLACE (City and state or country) Coffeyville Kan	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Andrew L Chapman		13b. MOTHER'S MAIDEN NAME Rose		14. NAME OF HUSBAND OR WIFE Maude Chapman	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address Mrs Maude Chapman 5707 E 24th St
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Arricular fibrillation DUE TO (c) Mitral stenosis		INTERVAL BETWEEN ONSET AND DEATH 2 days
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary infarcts		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour [REDACTED] a.m. [REDACTED] p.m. [REDACTED]	Month, Day, Year [REDACTED]
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION [REDACTED]	COUNTY [REDACTED]	STATE [REDACTED]
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21. I attended the deceased from [REDACTED] to 1963 and last saw him alive on 9-10-63 Death occurred at [REDACTED] m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Harry K. Cohen (Degree or title)	22b. ADDRESS 751 E 63rd St	22c. DATE SIGNED 9-11-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/13/1963	23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo	25. DATE RECD. BY LOCAL REG. 9-11-63	26. REGISTRAR'S SIGNATURE Bessie Smith
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

VS 300
Rev. 4/59

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Harry K. Cohen

Dr Harry Cohen
636 Argyre Bldg
Before 5:00

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Richard E. Conall

Licensed Embalmer No. 4829

P. O. Address KC MO.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.